President's International Mother and Child HIV Prevention Initiative Meeting

Victoria Junction Hotel
Cape Town, South Africa
June 3-5 2003

Executive Summary

Background

Representatives from U.S. Government (USG) agencies convened a meeting on the President's International Mother and Child HIV Prevention (PMTCT) Initiative in Cape Town, South Africa, on June 3-5, 2003. The primary purpose of the meeting was to exchange information among U.S.-based headquarters (H/Q) staff and USG field staff who are implementing the Initiative in the fourteen targeted countries in Africa and the Caribbean.

Sixty-one delegates attended the meeting representing the Global AIDS Program of the Centers for Disease Control and Prevention (CDC/GAP) of the Department of Health and Human Services (DHHS), the U.S. Agency for International Development (USAID), the U.S. Department of State, the Office of Management and Budget, the Office of National AIDS Policy, Office of the Secretary, DHHS (OS/DHHS), and the MEASURE Evaluation Project. Thirteen of the fourteen Initiative countries were represented by CDC and USAID field staff from Botswana, Ethiopia, Haiti, Ivory Coast, Kenya, Mozambique, Namibia, Nigeria, Rwanda, Senegal, South Africa, Tanzania, Uganda, Zambia, and USAID regional offices in Kenya (REDSO-ESA), South Africa (Southern African Regional), and West Africa (WARP).

Specific objectives of the meeting were to:

- Update field staff on the current status of the Initiative,
- Provide an opportunity for field staff to inform H/Q and share with field colleagues their programmatic experiences thus far in the Initiative,
- Work to complete the country Initial Obligation Plans (IOPs),
- Discuss and get feedback on the upcoming FY04 Implementation Plan (IP) application and process, and,
- Discuss best ways to jointly implement the Initiative.

Meeting Highlights

PMTCT Initiative Overview

Dr. Mark Dybul of OS/DHHS opened the meeting with an overview of the Initiative and its management at the headquarters level.

He explained that the Initiative is guided by a steering committee made up of representatives from NIH, DHHS, USAID, Department of State and ONAP. Led by ONAP, the process is further coordinated through six working bodies, or workstreams. Dr. Dybul also discussed the President's Emergency Plan for AIDS Relief, which plans to disburse 15 billion dollars over five years and builds upon the PMTCT Initiative.

Workstream Reports

Representatives from each Workstream provided an overview of issues and activities.

- The **Program Services Workstream** is responsible for developing the application process and review of the IPP, IOP, and IP and recommends approval of these plans to the Steering Committee.
- The **Procurement Workstream** is concerned with procurement of drugs and commodities for the Initiative and has focused on the establishment of an overarching mechanism to task out procurement orders. Its long-term goal is to build capacity and the guiding principle is the continued supply of appropriate drugs for

PMTCT and PMTCT plus activities. The Procurement Workstream has prepared a *Concept Paper for Drug and Health Commodity Procurement, Management, and Logistics for the President's Initiative.*

- The **Budget Workstream** focuses on the establishment of contracts, agreements and partnerships. It was confirmed that the Budget Workstream has established a framework for a joint contracting mechanism for USAID and CDC, but work is still being done to streamline the process and develop a set of step-by-step instructions.
- The **Human Resources Workstream** deals with human capacity development, including establishing special programs for institutional twinning and deploying a volunteer health care corps. A Twinning Center will be established to coordinate and provide technical assistance for these special programs.
- This **Monitoring & Evaluation Workstream** is concerned with the establishment of health management information systems. It aims to establish and implement a tool to collect and report data and to document progress of the initiative.
- The **Communications Workstream** aims to enhance the flow of communication between H/Q and the field and within the workstreams. Plans include the facilitation of a monthly meeting to assist with communications across all workstreams as well as a newsletter and possibly a website.

Country Reports

Representatives from each of the thirteen country programs gave brief overviews of the USG programs for the PMTCT initiative in their countries. They presented their program goals, implementing mechanisms, current partnerships, key approaches, and challenges.

Working Sessions on the IOPs

Participants worked in small groups to advance the work on their Initial Obligation Plans (IOPs). The IOP describes (in table format) plans for implementing the initial phase (i.e., through October 2003) of the country program for the initiative. The table includes projected funding obligations and draw-downs; implementing partners; funding mechanisms; and, measurable goals and activities. USAID and CDC country program partners worked together with H/Q representatives to complete the IOPs, which will be reviewed by the Program Services Workstream following the meeting.

Plenary Sessions

A series of plenary sessions were held to address emerging topics. Highlights from these sessions are outlined below.

- **Improving Communications**. Discussion focused on how to improve the flow of communication, including how to communicate best practices, how to communicate with each other in the field, and how to communicate between headquarters and the field. Suggestions emerging from the discussion included the following:
    - **Field to Field Communication:** Understand how each agency works to enable both agencies to work together effectively and complement each other; organize joint meetings with external agencies like the Clinton Foundation or the Global Fund; share information and use strengths to complement each other; share office space to harmonize collaboration; invest resources in formal team building; strengthen links with the Ambassador and Embassy staff; develop good systems of collaboration to fall back on when pressures emerge; introduce consultation sessions at the beginning or end of home-leaves.
    - **Headquarters to Field Communication:** Meet annually or bi-annually to network, share information and discuss technical issues; publish a newsletter; develop a website; compile 'toolkits' of sample material at H/Q, include practical information such as a menu of services, a contract format, new guidelines, etc.; employ a documentation person to track progress and to record the

experiences from the field; hold regular Workstream conference telephone calls; develop a standardized slide show about the Initiative; facilitate field participation in the workstreams.

- **Technical Input for USAID Document**. Participants were asked to provide technical feedback on the draft MTCT technical guidance document currently being updated by USAID. Suggestions were tabled and will be incorporated.

- **Implementation Plan (IP) Application.** H/Q staff presented an overview of the IP application process and reviewed the current draft application with participants. Part I of the Application consists of a progress report on the initial phase of the Initiative (i.e., accomplishments on plans outlined in the IOP), while Part II is an annual implementation plan for FY04. Participants provided feedback on some of the challenges they will face in providing the requested application information and noted areas where they will require additional guidance in order to complete the application.

- **Technical Assistance Needs**. H/Q staff asked field participants to identify their technical assistance needs in the upcoming months, including assistance in planning, procurement and contracting, and monitoring and evaluation. Participants discussed the types of assistance that would be helpful and completed a short written form that captured needs and schedule preferences. H/Q staff announced that they will develop plans for joint HHS-USAID technical assistance visits to country programs beginning in July.
- **Some Key issues raised by field staff (to be followed up by H/Q staff) included:**
    - Inadequate contracting mechanisms (primarily a CDC concern) and the need for more contracting support (primarily a USAID concern).
    - Human resources--lack of trained personnel to implement the initiative; issues/requests concerning policies on staff salary supplements; USG employment of MOH personnel directly or through contractors may threaten national capacity, which already has a dearth of manpower
    - Monitoring and evaluation—field request to streamline the large number of proposed core indicators; request for clarification on the definition of USG site vs. national site.
    - Need for better and timelier H/Q-field communications; request for participation of field staff in the Initiative workstreams.

Suggestions on how to move the Initiative forward were made and included:

- Schedule submission of Initiative plans and reports to coincide with other USAID and CDC planning and reporting cycles.
- Include field staff in the workstreams so that field perspective can be reflected in decision making process.
- A communications workstream is being formed. Various communications options were discussed including a web site, chat room discussions via internet, email with minutes of Workstream meetings, regular conference calls, a list serve, a newsletter, and regional meetings.
- Inform embassy, BNF and USAID contractors about the Initiative and its importance so as to get their full support and establish PMTCT as a priority.

Factors that have helped joint USG programming in the field were shared and include:

- Joint (USG) meetings with external partners and MOH officials that present the Initiative as a joint USG program
- Informing mission and ambassadors of joint team approach and the need to involve both agencies in discussions related to the initiative
- Weekly USAID/CDC meetings to update and share information
- Friendly relationships between personnel at CDC and USAID

Achievements/ Accomplishments:

- Meeting objectives were achieved: field staff got a better understanding of the Initiative and the Emergency Plan for AIDS Relief; relationships between H/Q and field staff were strengthened; participants remained engaged in the work throughout the 3-day meeting with much goodwill.

- The meeting provided an excellent forum for exchange of information between countries and between field and headquarters. A number of important issues were discussed and plans to address them were made.

- The meeting was an excellent opportunity for efficient completion of IOPs, especially to get consultation from OMB, ONAP, DOS, and H/Q HHS and USAID staff.

Next Steps

The meeting concluded with identification of events, deliverables and timelines for the next few months. The proposed schedule is outlined below. Participants agreed that the meeting was successful in achieving its objectives and recommended meetings like this be scheduled on a routine basis.

Event/Deliverable	***Schedule***
Twining activities	
HR Workstream to send draft RFA to field for input	13 June
IP Application	
Field comments on draft to H/Q	13 June
Field sends revisions on Country Profile information to H/Q	13 June
H/Q sends revised draft to Steering Committee	16 June
Technical assistance and preparation of IPs	July – September
Deadline for IP submission	1 October
Procurement Concept Paper	
Field sends comments to Procurement Workstream	13 June
Field sends comments on Pharmaceutical Assessment to H/Q	25 June
IOPs	
Field sends IOPs to Program Services Workstream for review	13 June
Steering Committee reviews IOPs	18 June

MINUTES

Attendance

Name	Title	Organization	E-mail
Achom-Okwero, Margaret	Technical Advisor for PMTCT	CDC/Uganda	mho8@cdc.gov
Akouathale, Valentin Noba	PMTCT Technical Advisor	CDC/Ivory Coast	afn9@cdc.gov
Allen, David	Country Director	CDC/South Africa	allend@sacdc.co.za
Allinder, Sara	Regional Advisor for the Western Hemisphere	Department of State	allindersm@state.gov
Allman, Jim	Health Public Sector Team leader	USAID/Tanzania	jallman@usaid.gov
Awantang, Felix	USAID/WARP/Team Leader	USAID/WARP	fawantang@usaid.gov
Barratt, Christian	HIV/AIDS Advisor	USAID/Mozambique	cbarratt@usaid.gov
Berger, Rene	Policy Analyst	USAID/Washington	rberger@usaid.gov
Bolu, Omotayo	Medical Epidemiologist	CDC/Atlanta	obolu@cdc.gov
Boni-Outtara, Edith	Presidential Initiative Focal Point	CDC/Ivory Coast	ehb8@cdc.gov
Bush, Adriel	OMB Examiner	Office of Management and Budget	abush@omb.eop.gov
Cunningham, Amy	HIV/AIDS Advisor	USAID/Uganda	acunningham@usaid.gov
Dempsey, Holly	HIV/AIDS Officer	USAID/Ethiopia	hdempsey@usaid.gov
Dioume, Ramatoulaye	HIV/AIDS Program Manager	USAID/Senegal	rdioume@usaid.gov
Dooley-Jones, Tina	Director of Technical Programs	USAID/Namibia	tdooley-jones@usaid.gov
Duncan, Wayne	Chief of Party	CDC/Nigeria	wcd2@cdc.gov
Dunford, Polly	PHN Division Chief	USAID/Haiti	pdunford@usaid.gov
Dybul, Mark	Office of the Secretary, HHS	DHHS/NIH	mdybul@nih.gov
Espeut, Donna	Reproductive Health and HIV/AIDS Specialist	Measure Evaluation (ORC Macro)	donna.a.espeut@orcmacro.com

Floyd, Leonard	CDC Deputy Director - Operations	CDC/Namibia	floydl@nacop.net
Gibbons, Amanda	MTCT Technical Advisor	USAID/Washington	agibbons@usaid.gov
Handley, Gray	International Health Attache	Office of the Secretary/HHS/Pretoria	handleyg@state.gov
Hunt, Trish	PMTCT Project Officer	CDC/Ethiopia	huntt@etcdc.com
Irish, Kerry	Consultant	Into the Limelight	kerry@intothelimelight.co.za
Jennings, Gerald	Biomedical Research Advisor	USAID/Washington	gjennings@usaid.gov
Jordan, Mary	Public-Private Parternships	USAID/Washington	majordan@usaid.gov
Joseph, Patrice	Program Specialist	CDC/Haiti	pjoseph@cdc.gov
Kasungami, Dyness	Reproductive Health Specialist	USAID/Zambia	dkasungami@usaid.gov
Kieffer, Mary Pat	Regional HIV/AIDS Advisor	USAID/REDSO	mkieffer@usaid.gov
Kilmarx, Peter	Country Director	CDC/Botswana	pbk4@cdc.gov
Koscelnik, Valerie	Chief of Party	CDC/Rwanda	koscelnikvx@state.gov
Kosko, Debra	Senior Technical Advisor, Office of Population, Service Delivery Improvement Division	USAID/Washington	dkosko@usaid.gov
Kuritsky, Joel	Senior Consultant, PMTCT, GAP	CDC/GAP/Atlanta	jkuritsky@cdc.gov
Lazell, Kirk	PHN Officer	USAID/Namibia	klazell@usaid.gov
Mani, Nithya	Field Communication Coordinator, USAID, Office of HIV/AIDS	USAID/Washington	nmani@usaid.gov
Marum, Lawrence	Medical Epidemiologist	CDC/Kenya	lmarum@cdcnairobi@mimcom.net
Mbori-Ngacha, Dorothy	National PMTCT Coordinator CDC/GAP	CDC/Kenya	dngacha@cdcnairobi.mimcom.net
Mercier, Pierre	Population Advisor	USAID/Haiti	pmercier@usaid.gov
Moloney-Kitts, Michele Russell	PHN Officer	USAID/Washington en route to USAID/Southern Africa Regional	mmoloney-kitts@usaid.gov
Musah, Aleathea	Deputy General Development Officer	USAID/Nigeria	amusah@usaid.gov
Mwinga, Alwyn	Medical Epidemiologist	CDC/Zambia	amwinga@zamnet.zm

Nelson, David	Director	CDC/Zambia	nelsond@zamcdc.org.zm
Nnorom, Joseph	Chief Epidemiologist	CDC/Nigeria	jnnorom@hotmail.com
Nolan, Monica	African Regional Technical Advisor - Presidential Initiative	CDC/Ivory Coast	mnolan@cdc.gov
Russell, Michele	Regional HIV/AIDS Program Coordinator	USAID/Southern Africa Regional	mrussell@usaid.gov
Saifodine, Abuchahama	Public Health Advisor	USAID/Mozambique	asaifodine@usaid.gov
Settergren, Susan	Consultant, Office of the Director, CDC/GAP	CDC/GAP/Atlanta	ssettergren@cdc.gov
Shelley, Karen	Senior Technical Advisor for HIV/AIDS	USAID/Zambia	kshelley@usaid.gov
Simonds, RJ	Chief, HIV Care and Treatment Branch, CDC/GAP	CDC/GAP/Atlanta	rxs5@cdc.gov
Smith, Monica	PMTCT Counseling Advisor	CDC/Botswana	smit1@cdc.gov
Sow, Barbara	Technical Advisor for HIV/AIDS/Acting PHN Officer	USAID/Rwanda	bsow@usaid.gov
Stanton, David	Division Chief, Technical Leadership and Research, Office of HIV/AIDS	USAID/Washington	dstanton@usaid.gov
Stewart, Karen	Special Assistant	Office of National AIDS Policy	karen_l._stewart@opd.eop.gov
Strong, Michael	Senior Health Program Manager	USAID/Kenya	mstrong@usaid,gov
Swai, Patrick	Program Management Specialist	USAID/Tanzania	pswai@usaid.gov
Swartzendruber, Andrea	PMTCT Technical Officer	CDC/GAP/Atlanta	zpi7@cdc.gov
Treger, Latasha	PMTCT Program Officer	CDC/South Africa	ltreger@sacdc.gov
Wadhwa, Nina	International Health Fellow	USAID/Washington	nwadhwa@usaid.gov
Wilson, Melinda	Senior Advisor for HIV/AIDS and Reproductive Health	USAID/South Africa	mwilson@usaid.gov
Wuhib, Tadesse	Country Director	CDC/Ethiopia	twuhib@etcdc.gov

Welcome and Introductions

Mark Dybul, Office of the Secretary, HHS

Mark expressed gratitude for everything done by this group whose work has been instrumental in the introduction of the US President's Office's Emergency Plan. Joe O'Neill from the Office of National AIDS Policy (ONAP) expressed his regret that he was unable to attend the meeting. It was emphasised that the purpose of the meeting is to share information and to learn from each other.

Overview of MTCT Initiative and Emergency Plan

Amanda Gibbons, MTCT Technical Advisor, USAID, Washington and Mark Dybul, Office of the Secretary, HHS

Amanda highlighted that on 19 June 2002 President Bush announced the United States Government's (USG) President's Initiative, comprising two components:

- To build Mother-to-Child HIV Transmission (MTCT) prevention services
- To build healthcare delivery systems

The initiative is guided by a steering committee made up by representatives from ONAP, DHHS (OS, NIH, CDC, HRSA), USAID, Department of State, and Office of Management and Budget. The process is coordinated by ONAP and monthly meetings are held to update the stakeholders.

The process is further coordinated through five US working bodies – or "workstreams":

- Program services: Concerned with Initial Program Plans (IPP), Initial Obligation Plans (IOP) and Implementation Plans (IP)
- Budget: Concerned with contracts, agreements and partnerships
- Human resources: Concerned with human capacity, including twinning and a volunteer health care corps
- Monitoring and Evaluation: Concerned with health management information systems and reporting
- Procurement: Concerned with procurement of drugs and other commodities

To date all countries at this meeting have completed IPPs, however there was a need for more detail, specifically for the budget hence the IOP was introduced. Haiti, Guyana, Kenya and Uganda have already had their IOPs approved.

The IOP attempts to pair up funding with outcomes for the first six months. The IPP and IOP are initial steps, which won't be repeated on a regular basis. The IP is a plan that will be developed annually and will provide detailed annual plan for the initiative.

It was emphasised that the Initiative represents an interagency activity, a new way of doing business presenting exciting opportunities.

Amanda concluded that during this meeting the names of those involved in workstreams and the steering committee would be circulated to participants.

Discussion

Valerie Koscelnik, CDC, Rwanda, asked about the meeting that was scheduled for 22 May 2003. It was confirmed that Secretary Thompson met with fourteen ministers including Rwanda's Minister for Health, to announce that the Global AIDS Bill had been passed. *Valerie* added that the Rwandan government had appointed a Minister for AIDS and therefore the Minister of Health might not be best contact person – both should be targeted.

Michael Strong, USAID, Kenya emphasised the importance of communication saying that the Minister of Health in Kenya was not aware of the IOP process and was under the impression that all money was coming directly to the Kenyan government

Amanda noted that future meetings are likely to occur and the Department and USAID have prepared documentation in advance for these sudden meetings. *She also* highlighted that there is a new workstream focusing on communication. She called for any suggestions to improve the flow of communication saying that the challenge is to most efficiently get the message out to all in the field.

In response to a question about whether there is clarity around the IOP/IPP process at the top it was confirmed that the steering committee members have been actively involved from the outset.

Emergency Plan for AIDS Relief

Mark noted that these discussions would lay the groundwork for PMTCT initiative within the umbrella of the Emergency Plan. He commended participants for all the work, speed and energy displayed in the development of the IPPs, which enabled Joe O'Neill to spearhead the Emergency Plan at the White House. Further he noted that the Emergency Plan gives us the opportunity to help people fundamentally – we have the ability to change the way we operate in combating the disease. The President announced the Initiative - which plans to disburse 15 billion dollars over five years - on Jan 28, 2003. The Initiative received the overwhelming support of Senate and Congress getting passed through Congress within two weeks. The Plan is designed to be fully comprehensive encompassing prevention, care and treatment – it includes the ABCs of HIV/AIDS prevention, and all the other types of things we think about in terms of prevention, as well as care and treatment.

He went on to highlight some of the goals of the Initiative:

- To prevent seven million infections
- To provide care for ten million people
- To treat two million HIV-infected people
- *Mark* explained that this is a bold plan that takes a quantum leap. Its overwhelming support from Congress has allowed President Bush to encourage other countries to get involved in similar initiatives. Ten of the fifteen billion dollars are new funds (the remaining five billion is existing including funds from USAID etc.)

H/Q also informed participants that an ambassador-level Global HIV/AIDS Coordinator for HIV will be appointed by the President and confirmed by the Senate. This individual will be charged with organizing the entire US Initiative and to drive the USG's international HIV/AIDS activities. The coordinator has not yet been named. Therefore our understanding is somewhat limited but at least we're moving forward since we know the authorization is there.

He remarked that there has been much discussion about the Ugandan model, but clarified that the USG acknowledges that it can't simply impose a US structure and aims to work with countries to develop appropriate national HIV strategies and fully integrated National Plans providing a national system for urban and rural areas. So while Uganda

represents a potential model we need to work with the specific needs and infrastructure of each country and not all countries will be based on Uganda's model.

Mark concluded that this represents an exciting opportunity to help so many people.

He added that many of the IPPs have outlined how the PMTCT initiative will fit in with the National Plan . The development of infrastructure in these countries will provide a platform for other health issues. This bold vision has the potential to fundamentally change healthcare in these countries.

Discussion

A question of timeframes emerged - particularly about when countries will be expected to report on the numbers of women served in the MTCT Initiative. It was noted that the USG appreciates that some countries will move faster than others and that each situation is unique. Each country will therefore develop its own performance outcome measures. Performance will not simply be measured by numbers and will also look at aspects such as the quality of services, improvements in infrastructure and so on. The reporting of numbers achieved will be requested bi-annually through progress reports.

One participant emphasised sustainability saying that the delivery of drugs alone won't help.

Amy Cunningham, USAID, Uganda emphasised the need to expand thinking beyond systems for health delivery by also looking at communications, partnerships with the private sector and reproductive health – all critical areas which stand to benefit from these new resources.

Mark agreed and emphasised the need to build a community base to get people involved. For example, in Botswana people aren't visiting the clinics even though these facilities exist. Community mobilization will be a central focus of the Emergency Plan, along with the development of public private partnerships.

It was noted that the Global AIDS Bill which was distributed at this meeting addresses many of these issues including a strong emphasis on infrastructure development, women's health, a multi-sectoral community-based approach, public private partnerships and so on.

Concern was raised that while we spend time negotiating and planning with country nationals in the Ministries of Health, they aren't here today. Questions were raised around how to connect with national partners who are actually implementing plans on the ground, and how CDC and USAID can become integrated partners.

It was also noted that many countries are implementing PMTCT programs as part of their Global Fund activities – and sometimes these funds are bigger than the PMTCT Initiative which requires a lot of paper work and so concerns were raised about the implications of further reporting. There was an appeal to reflect on how we can bring the Atlanta/Washington perspective a bit closer.

Mark responded that there is obviously no intention to bypass nationals and the ambassadorial representative will be the focal point. He emphasised that national plans can only be built by nationals. These people will be targeted in the building of the plan and this is the only way in which it will be sustainable. He re-emphasized that this will not be USG initiative in-country but rather a national initiative inviting inputs from all the appropriate stakeholders.

The duplication of Monitoring and Evaluation is a valid point and he confirmed that the Initiative was working on reporting together with the Global Fund and World Bank so that countries aren't burdened with multiple reporting systems.

This will be further streamlined when the State Coordinator for HIV/AIDS has been appointed in ONAP.

Michele Maloney-Kitts, USAID, Washington advised those coordinating the Initiative to be clear about the meaning of multi-sectoral. It could encompass everything from HIV prevention messages to changing the type of crops produced. A working definition of multi-sectoral is necessary to ensure common understanding.

Mark reassured participants that this would be clarified – at this stage the documentation uses a lot of legalese but concepts will be spelt out and defined in the appropriating language.

David Stanton, USAID, Washington was asked to comment on ONAP's vision for integrating strategies to ensure that those in the field are not perpetually working on developing programmes. *David* replied that this is still a question facing USAID.

It was confirmed that the State coordinator would be responsible for the coordination of all HIV/AIDS activities (the entire 15 billion dollars allocated towards HIV/AIDS). This centralized coordination represents opportunities for systematic and comprehensive strategic direction.

It was confirmed that the State Department would have a sense of the structure of the Coordinator's Office by the end of August 2003.

It was suggested that some of those involved in the establishment of the Coordinator's Office should visit the field to see how things work on the ground. It was confirmed that NGOs are putting together visits for appropriators and although time is short it was hoped that a sense of the enormity of the task will sink in.

Workstreams

Gerald Jennings, Biomedical Research Advisor, USAID, Washington

Chairing this session, Gerald Jennings introduced four of the workstreams – procurement, program services, human resources, and monitoring & evaluation. He said that each workstream is comprised of representatives from USAID and CDC in Washington along with field representatives; for example, John Crowley from South Africa is a member of the procurement workstream.

Program Services Workstream, Rene Berger, Policy Analyst, USAID, Washington

Rene highlighted that an important aspect of the workstreams is that they are all ***joint USAID and HHS-led***. He explained how the Program Services Workstream had a responsibility of developing the IPP, IOP and IP reporting process and is the first technical review through which documents will pass, followed by the Steering Committee. Participants should, therefore, direct any questions to Program Services, who act as a type of umbrella for all workstreams, but especially as a technical review team. Within Program Services there is a good internal balance between CDC and USAID and country experts are consulted when necessary.

He explained how the Program Services was made up of a small technical working group and their role is to highlight what field staff need to explain to the central office so that they can receive the necessary funding for their programs. He reminded participants that the workstream structure is not static and suggestions to refine the structure are welcome.

Discussion

In response to a question about country representation at the workstream level it was noted that although attempts have been made to get participation from countries this has probably not been as successful as it could have been, particularly with difficulties posed by time differences and so on. Rene said that it would be great to get names at this meeting of individuals who would be interested in participating in the workstreams, which mainly take place through conference calls.

Responding to a question about communication, H/Q staff confirmed that they were aware of delays in communication and said that this is an ongoing challenge with which they are grappling. It was noted that the central office is exploring a number of methods to enhance communication with the field including the possibility of a monthly e-mail newsletter to update participants about developments in the workstreams. However it was noted that there is a balance of communication and the US is cautious about bombarding fieldworkers with information. High workloads and the need for consultation around documents submitted by the fourteen countries are some of the reasons which delay the turnaround of documents.

Felix Awatand, USAID, West Africa Regional Office expressed concern at the high levels of time-consuming paperwork and the bureaucratic processes involved in getting workplans approved.

USAID, Washington reassured participants that they don't envisage much additional work saying that the new workplans (IPPs, IPs, IOPs) and strategies should be seen as an expansion of the existing country strategies in slightly greater detail – Thus the IP would be an extension of the Annual Report. They cautioned that as resource levels have gone up, so too have the levels of scrutiny, highlighting the increased importance of having good programs in place and ensuring that the greatest impact is achieved.

It was noted that President Bush has emphasised that budgets are linked to performance outcomes. However the USG agreed that there was certainly a need for a more streamlined process.

One participant expressed that there is a perception in the field that workstreams are not communicating with each other and are therefore creating unnecessary paperwork by asking the same questions. An appeal was made for workstreams to talk to each other and streamline their questions.

H/Q staff agreed saying that they certainly plan to be more systematic in future. The workstreams will communicate on a monthly basis and only Program Services will communicate with the field. It was reiterated that participants were welcome to make any additional suggestions.

It is also expected that there will be some sort of annual document solution, similar to the existing annual report where countries report on resource and highlight any changes. Once we enter IP phase it will be less onerous as the initials (IPP and IOP) would fall away. CDC and USAID are also planning on harmonizing their reporting requirements by developing a simple standardized format to be filled out by both agencies in all countries.

Procurement Workstream, Joel Kuritsky, Senior Consultant, PMTCT, GAP, Atlanta

Joel referred participants to the *Concept Paper for Drug and Health Commodity Procurement, Management, and Logistics for the President's Initiative* asking them to comment once they had had an opportunity to go through it.

Joel said that the ongoing effort to deliver commodities to programs has received extensive consideration at the Washington level over the past four months with the key players in procurement. A central question is the establishment of an overarching mechanism (a one-stop-shop) to task out orders. The Procurement Workstream has approached the Budget Workstream and is attempting to develop an agreement that will suffice for both agencies along with their contract and project offices.

He said that the long-term goal is to build capacity and the guiding principle is the continued supply of appropriate drugs for PMTCT and PMTCT plus activities.

It was noted that a large portion of relief is going towards ARVs for People Living with HIV/AIDS (PLWHAs).

Joel referred to the timeline in the concept paper saying that the next step is to do an assessment. He cautioned that the scope of work for the over-arching mechanism will only be available in six to nine months and recommended that countries continue to use their existing mechanisms for purchasing commodities.

In the meantime a menu of services is to be compiled containing useful information such as the MSF list of generics, products, prices, web links, and information about a document produced by RPM Plus.

With regard to the lab side there is to be an investigation into the minimum requirements for monitoring people on ARVs.

Discussion

There was a discussion about obtaining generic ARVs directly from the Departments of Health through CDC. It was noted that there is still no policy on generics and therefore TRPS continues to apply – The White House will be issuing a memo to grant permission but if countries meet TRPS requirements they can obtain generic HIV drugs. There was a suggestion that countries receive technical assistance around the TRPS requirements.

David Stanton outlined some interim measures for countries that need to obtain cost-effective commodities before the establishment of the over-arching mechanism. He said that there is still a need to clarify the issues surrounding the purchase of generic drugs and hope that countries would be given access to generics however he said the FHI is allowing the purchase of drugs from various non-US sources.

He further noted that the USG has issued blanket waiver on the purchase of non-FDA approved test kits, which seems to be working and he hopes for further blanket-waiver type clauses.

Peter Kilmarx, CDC, Botswana noted that in Botswana there are plenty of woman getting AZT and ARVs are popular and he asked about the long-term goal of capacity building.

It was noted that the long-term goal is to strengthen local procurement and distribution to ensure sustainability. RPM will be conducting the training around procurement and this can be requested by the countries, although it may be

standardized. The difficulty is that the Initiative wants to build a sustainable system but also wants to put drugs in place as soon as possible.

It was noted that there are also elements of palliative care built into the procurement formula. The problem of finding a suitable substitute for breast milk was cited and there was a call for ideas around this issue.

Mark said that the Initiative is in a strong negotiating position, especially with generics saying that the pharmaceutical companies are smart. They are dropping prices so that they're competitive and may even guarantee distribution and include training. Ultimately they might work out cheaper than generics.

He added that although it may sound very centralized the advantage of doing this early on is that we could get buy-in from the pharmaceutical companies at the outset.

Budget Workstream , Joel Kuritsky, Senior Consultant, PMTCT, GAP, Atlanta

It was confirmed that the Budget Workstream has established the framework for a joint contracting mechanism. The USG will let a single RFA, to which potential contractors will apply and which will be reviewed by a joint panel from both agencies. Each agency can then establish a separate contract with the contractor that is fully coordinated with the other agency. It allows for flexibility and for both agencies to be at the table without burdening partners. The Workstream is still working on streamlining the process and will develop and set of step-by-step instructions.

Human Resources Workstream, RJ Simonds, Chief, HIV Care and Treatment Branch, CDC/GAP, Atlanta

This workstream is co-chaired by Estelle Quain (USAID) and Laura Cheever (HRSA). This workstream is generally concerned with human capacity development, but the two main issues on which it is initially focusing are establishing programs for twinning and a volunteer health care corps, two special programs announced by the president as part of this initiative.

A draft RFA for a twinning center has been developed and is currently in the final stages of review by the Steering Committee. An RFA would fund an organisation to coordinate twinning activities, providing technical assistance and an evaluation of twinning partnerships.

Twinning can be defined as a formal relationship between two organizations. It does not limit participation to partnerships between US-based and in-country organizations but does allow for country-to-country partnerships. Twinning will include NGO and governmental organization partnerships.

The type of organization involved is also not limited to health-care providers (in the past it has mainly been thought of as hospital-to-hospital) but includes NGOs, academic institutions, professional organizations, community-based organizations and others.

The identification and management of twinning partners is a responsibility of the field programs. The Twinning Center will assist to ensure that the maximum benefit is obtained. As currently envisioned, the twinning center won't be responsible for the provision of resources in country, which are to be provided through the IP budget. It was reiterated that in twinning, as in procurement, the point of the central organization is to provide support and relieve burdens, and should not be seen as a controlling body.

Although the details have not been decided, the Peace Corps has confirmed its interest in establishing a mechanism to provide volunteer medical workers. The mechanism for disbursing travel funds, per diems and so on to the health corps is also still to be finalized.

In the first year the twinning relationships that will be promoted include existing partnerships like CDC-funded partnerships with universities and so on.

In response to a question about existing corporate partners it was noted that there are currently no large corporations who are involved in twinning relationships.

In terms of identifying potential twins it was noted that there would be a variety of ways of identifying new relationships. The USG could compile a list of potential organizations in the US. Partners in the field are also a potential source for the establishment of twinning relationships. Fieldworkers were asked to inform H/Q of the kinds of twinning relationships they need.

The vision is that over time the US will provide less support in terms of HIV services as these will be increasingly achieved through twinning partnerships. The Twinning Center will continue to provide training and support.

In terms of funding, the RFA will be funded centrally.

There was a suggestion that the Human Resource Workstream could tackle the problem of the brain drain by looking at ways of funding government positions to ensure that the talent is retained and people who remain in in-country positions are supported.

Monitoring & Evaluation (M & E) Workstream, Andrea Swartzendreuber, PMTCT Technical Adviser, CDC/GAP, ATLANTA

Co-Chairs: George (CDC) and John (USAID). Other members: Nathan.

The aim is to establish and implement a tool to collect and report data and to document progress.

Update on activities

Feb – May:	Baseline assessment
March – April:	Development of draft indicators and action steps (with input from representative of all workstreams)
May 6-7:	Work with Program Services to develop draft IP and finalize indicators
May 27:	MIS workshop for PMTCT, PMTCT+ and ARVs
June – August:	Country assistance / technical support to develop IP and monitoring and evaluation plans.
Indicator Matrix:	Planning/Inputs - Services Available – Outcomes - Impacts

With regard to indicators it was confirmed that reporting of core indicators would be required annually. All countries must report on USG level core indicators and reporting on national-level core indicators would be encouraged.

With regard to reporting it was confirmed that semi-annual report would be due thirty days after the reporting period (30 April) and an annual report would be due in December.

It was further noted that at least one person should be responsible to both CDC and USAID for the coordination of monitoring and evaluation and joint reporting to H/Q. The Emergency Plan will require complex systems and different methodologies including patient management and program monitoring and evaluation.

The first step is to develop simple and reliable systems to monitor PMTCT. The next is to introduce technical assistance to develop and review monitoring and evaluation plans and IPs, along with evaluation studies for systems for care and treatment.

In terms of the indicators it was asked whether requirements for additional data, such as survey data, would not place a greater burden on reporting and how surveys would make a real contribution. In response it was noted that survey models will be based on known data and small survey conducted at sentinel sites will be used to test these models. There was an appeal for assistance in the selection of sentinel sites. It was further noted that this is the type of assistance the Workstream envisages that it would supply in terms of the development of a monitoring and evaluation plan. Finally it was confirmed that PCR analysis would be required at sentinel sites.

The Workstream will finalize the timeframes along with the IP guidelines and they emphasized that what they come up with is of most value to the field, which is one of the reasons that this meeting was taking place.

Participants were reassured that for those who would most appreciate technical assistance that this would be discussed.

With regard to the scope of reporting it was asked how we are reporting on the overall US impact. It was confirmed that the aim is to try and quantify the US impact on number of women served, although it was acknowledged that capacity building is difficult to measure. One possibility would be to look at national numbers alongside US numbers.

Tadesse Wuhib, CDC, Ethiopia noted that indicators would be different within each country. H/Q said that they have highlighted the core indicators and are aware that there will be country-specific indicators. They said that they appreciate that countries are starting at different points but the recording of such data enables the measurement of progress.

Communications Workstream, Nithya Mani, Field Communications Coordinator, Office of HIV/AIDS, USAID, Washington

Nithya highlighted that one of the functions of the Workstream is to facilitate a monthly meeting to assist with communications across all workstreams. *Nithya* called for any ideas to enhance the flow of communication and noted that several suggestions have been made so far including a monthly newsletter and possibly a website. She commented that communications would be discussed in greater detail later in the meeting.

Country Report-Back

Amanda Gibbons opened the afternoon session and introduced Haiti as the first country to submit their IOP.

Haiti

Facilitated by Patrice Joseph, CDC, Haiti, Pierre Mercier, USAID, Haiti and Polly Dunford, USAID, Haiti

See Appendix 1

Appendix one provides an overview of the Haiti PMTCT Program and their IOP. Pierre highlighted the existence of a national strategic plan developed in a collaborative effort through a public private partnership between Gheskio and the Department of Health in Haiti, which called for a nation-wide strategy to expand HIV/AIDS services.

Discussion

Haiti was commended on its IOP because it contains a detailed description of the magnitude of services and what currently exists, since this makes analysis and measurement of progress possible. In terms of completing IOPs there is a need for as much specificity as possible when dealing with human resources. Regarding the hiring of staff, H/Q is interested in their purpose, whether they are foreign or national staff, payment mechanisms and so on. It is not sufficient just to indicate how many staff will be hired. It was noted that in the IOP clinic staff and management do not fall under human resources.

Nigeria confirmed that they are already using ARVs and have begun to implement PMTCT plus. Haiti responded that in their model if a patient were already receiving HAART this wouldn't be curtailed. In Haiti it is the women who have already given birth who are on HAART.

In terms of people being hired for the Initiative if they are serving certain functions they should be categorized in their relevant section. The Human resources category focuses specifically on capacity building and training rather than being a blanket category to account for all the people you plan to hire. Staff employed by collaborating agencies do not need to be entered into the IOP.

A question was raised about the definition of PMTCT and what types of activities would be covered by this Initiative. For instance would it include STI prevention and treatment? In response it was clarified that for the purposes of the Initiative USG requires direct and measurable impacts on PMTCT and Haiti, for example, says they have an integrated approach and are using other funds to supplement the PMTCT. It was agreed that the improvement of services, infrastructure and equipment would be covered since these are integral to the success of the Initiative.

Peter Kilmarx, CDC, Botswana asked for more guidance in terms of the definition of PMTCT activities. *Rene Berger, USAID, Washington* responded that H/Q would prefer not to be prescriptive and would rather ask countries to make proposals around what they would like to do. It was noted that USAID does give guidance and any gray areas could be flagged for further discussion with USAID. Field workers felt that some broad guidelines would be useful.

It was reported that fieldworkers would also appreciate broad technical guidance around such issue as infant feeding, Nevirapine resistance and the appropriate use of formula. It was noted that break out sessions would be held the following day to determine areas where H/Q can provide guidance in terms of the formulation of IPs.

In light of low public sector salaries, participants were cautioned that the use of funding or salary supplements for doctors and nurses needs to be done prudently as it runs the risk of destabilizing the public sector. The lack of human capacity in the fourteen countries was cited as an issue and was flagged for further discussion.

Michele Maloney-Kitts reported that this issue of salary supplements is central to this initiative and perhaps the traditional stance on salary supplements needs to be reconsidered to prevent increasing brain drain.

In response it was noted that these are some of the reasons why the IOPS require detailed descriptions with regard to the hiring of staff. Participants were reminded that IOPS pertain only to the next six months and unfortunately there is currently no relief for direct hires.

There was a discussion about 'drawing down' and it was concluded that this occurs only when the in-country representative actually pays the contractor.

Nithya identified five groups to work together on their IOPs in a breakaway session, in preparation for the Country Presentations, which were to take place the following day.

Wednesday June 4

Country Report Back on IOPs

Kenya

See Appendix 2, contains summary of Kenya's demographic,implementation plan and IOP

Discussion

Monitoring and evaluation emerged as a key discussion point. It was noted that in Kenya's National Guidelines there is a section outlining their approach to monitoring and evaluation, which they have tried to keep as simple as possible: There are currently 13 data points where activity is monitored. This data translates into seven indicators. Data collection includes:

- The number of new and returned antenatal visits
- The number of women who learnt their status while receiving maternal or antenatal care
- The numbers of women who, after delivering, receive:
    - Counseling about HIV and prevention
    - An opportunity to receive counseling and testing before leaving hospital
    - An opportunity to obtain specific and appropriate counseling on infant feeding

On a quarterly basis the aim is to capture data in a centralized spreadsheet gathered from all facilities represented at a district, provincial and national level.

Nigeria

Joseph Nnoram, CDC, Nigeria and *Aleathea Musah, USAID, Nigeria* presented their draft IOP that focuses on Centers of Excellence as a model framework. In Nigeria this comprises of four teaching hospitals (also called centers of excellence (COEs)each with five satellite delivery points. The plan is to provide PMTCT plus services at the 4 COEs followed by expansion to the satellite clinics which will provide PMTCT services in the first phase. As a second phase expansion will continue to occur in other centers. All facility based activities is been planned in collaboration with the MOH and other partners. Community based activities including outreach and community mobilization are being planned around the centers and the satellite clinics, this will be implemented by USAID's collaborating partners. Two of USAID/CDC Nigeria's guiding principles are that it should be facility-based and community-based. As a first step to implementing the initiative, twelve master trainers have just been trained at the University of Maryland, the master trainers are going commence training of other health workers at the COEs and satellite clinics.

Discussion

Mark Dybul suggested that the section dealing with monitoring and evaluation in Nigeria's IOP should be more specific.

Amy Cunningham, USAID, Uganda, commented that the country presentation had raised points relevant to the Ugandan experience. She noted a lack of counseling skills in Uganda and asked whether Nigeria's twelve master trainers would also be dealing with the issue of counseling in Nigeria. In response, it was noted that in addition to midwives, there is a separate cadre of counselors. It was highlighted that in Uganda the program will be targeting NGOs, CBOs, nurses and others, to ensure that all services are provided at one point. In Kenya there are also attempts to ensure that the antenatal nurse midwife provides a comprehensive service because the uptake is higher than when this function is separated.

Joseph confirmed that only one of the sites in Nigeria currently focuses on PMTCT and there is a dedicated counselor/ midwife however, the plans is to have some dedicated counselors in the other sites. The program is also collaborating with the Ministry of Health to get more staff in the teaching hospitals.

Botswana

Peter Kilmarx, USAID, Botswana and *Monica Smith, CDC, Botswana* delivered a PowerPoint Presentation focusing on the current situation in Botswana and planned activities for the program.

See Appendix 3

Discussion

Once again the question of counseling emerged and there was a question about the duration of training for lay counselors.

In response, it was reported that counselors are high-school graduates and salaried government employees who receive four weeks of training. They also provide counseling and support for ARV programs and are supervised by clinic nurse. They have resulted in an increase in the number of women who receive counseling. The importance of having support structures in place to assist them in their work was also highlighted.

In response to a question about why nurses aren't doing counseling it was noted that they are unable to spend sufficient time with those who require counseling.

With regard to the public/private mix in Botswana it was established that the private sector is not involved. *Peter* said that its quite simple because in Botswana everything is provided by the government. He acknowledged that there are some mining facilities providing PMTCT but they take their lead from government.

Referring to the statistics in the presentation it was mentioned that the prevalence seems very high among pregnant women in comparison to the national average.

Monica agreed that this is hard to explain since the program data matches the survey data. She speculated that the data might not have been reliable at this stage.

Due to the seriousness at the situation in Botswana there was a question about whether there were any activities being conducted at a policy and advocacy level. The situation seems to call for a radical approach, which leaves no time for pilot testing.

Monica confirmed that the government generally doesn't accept testing although pilots are being conducted around Nevirapine because there has been some resistance to it. She added that the rapid test is also not accepted and the standard ELISA method is still in use.

It was suggested that it would be worth investing in advocacy work to create a more conducive environment. *Peter* agreed saying that the program is involved in a working group at the highest level working with the President to accelerate such advocacy. He felt that this engagement has been fairly constructive although responses have been mixed. He added that within his CD there are some problematic issues. For instance posts funded over twenty months ago remained unfilled. He concluded that the President is supportive and recently announced his own status.

Zambia

Dyness Kasungami, USAID, Zambia revealed that USAID started working with the Central Board of Health on PMTCT in 1999. It was reported that there is a strong collaborative relationship with the Central Board of Health. They aim to establish nine centers based on the Centers of Excellence model where PMTCT will be rolled out. There is a special emphasis on the establishment of integrated programs - a challenge emerging from the Atlanta vision.

National indicators have been developed focusing on three areas:

- Training
- Service Delivery
- Facilitation

Plans for the program include:

- Expanding PMTCT to all provinces - There are currently 44 PMTCT sites but this still does not amount to one in each province

- Enhancing monitoring and evaluation
- Increasing male involvement through the testing of couples
- Encouraging women to visit a PMTCT/VCT site before they get pregnant, that is, during the family planning phase
- Lobbying around policy issues
- Introducing couple counseling
- Working around challenges associated with Nevirapine
- Establishing a database on counseling and testing
- Using some PMTCT funds to incorporate indicators into the existing Voluntary Counseling and Testing database resulting in a national system
- Working towards becoming integrated in the national system

Challenges

- The high costs associated with the increase in activities and more staff
- Integrating PMTCT into reproductive and maternal child health services
- Building on government infrastructure and expanding antenatal services
- Operating within a depleted system where many nurses have gone to Botswana
- Aiming to counsel all women who obtain antenatal services has led us to depend on volunteers. Their remuneration is a challenge.

Dyness pointed out that the program has established a partnership with the University of Alabama (UAB) and she asked which category they would fall into on the IOP (Twinning, Program Services, Human Resources or Monitoring and Evaluation) since UAB is partnering with a teaching hospital. She said that perhaps it would be worth considering more traditional categories like 'contract' or 'procurement' instead of the program areas: program services, procurement, human resources etc), which appear artificial.

Discussion

Amanda Gibbons, USAID, Washington responded to the question about where to place the University of Alabama, saying that the format of the IOP was debated extensively, particularly around whether it should be categorized by

partner or program area. She suggested that the University of Alabama would fall in both the Twinning and Program Services categories.

It was noted that this categorization might be subjective and open to interpretation.

Valerie Koscelnik, CDC, Rwanda, agreed that her work didn't slot easily into these categories, saying that in Rwanda they tended to use the structure of the health system in their planning.

Cote d'Ivoire

Edith Boni-Outtara, CDC, Cote d'Ivoire and *Monica Nolan, USAID, Cote d'Ivoire* delivered a PowerPoint Presentation to highlight the current situation in Cote d'Ivoire, future plans and their IOP.

See Appendix 4

Discussion

Monica stated that in terms of the anticipated arrival of funding from the Global Fund and the President's Initiative, flexibility is a challenge to ensure that programs are able to utilize whichever funds arrive first.

Monica also revealed that the relationship between Ministry of AIDS and the Ministry of Health has undergone various changes. Initially the government prioritized the Ministry of AIDS, which blocked progress in the Ministry of Health. Currently both ministries are at the same level, with the Ministry of AIDS responsible for advocacy and the Ministry of Health responsible for service delivery. The current configuration seems workable.

Amanda Gibbons noted that some countries had been struggling with language barriers and that there seems to be an opportunity for sharing between countries from similar language groups.

Uganda

Amy Cunningham, USAID, Uganda and *Margaret Achom-Okwero, CDC, Uganda* highlighted the National PMTCT program in Uganda and then looked at the USG approach and the opportunities facing the program.

See Appendix 5

In their IOP Uganda indicated that they had adjusted the areas of Human Resources, Program Services and Procurement and clustered them as 'Support to the National PMTCT Program'.

Three main areas have been identified:

- Coordination: training, communication, monitoring and evaluation and logistical development
- Training: training of trainers and staff training
- Program services: supporting the actual delivery of services

Discussion

The difference between obligating versus drawing was discussed. While they are still working on issues like training, Amy Cunningham indicated that they plan to enhance their solution over the next six months and will be able to obligate the bulk of funds. Their primary guiding principle is to ensure that their activities are supporting the national program.

With regard to a question about procurement mechanisms and whether they have been established specifically for ARVs it was noted that procurement is done centrally – although this has been debated. An ARV committee has been established with a view to securing generics as emergency drugs.

It was acknowledged that while there is no policy on counseling they have recognised that they cannot rely on the services of midwives to extend to counseling. As such they have obtained the services of peer counselors and are encouraging the public services to provide counselors to support the midwives.

Michele Maloney-Kitts was struck by how much higher the prevalence is in women compared to national averages. She also commended the program's focus on family planning and mentioned that she is involved in developing some useful advocacy tools to demonstrate that family planning is more cost-effective than relying on PMTCT alone, with an integration of both approaches being recommended.

In response to the discrepancy between the national prevalence and antenatal prevalence the LRH have responded that this is due to a significant range in the responses.

Mozambique

Christian Barratt and Abuchahama Saifodene, USAID, Mozambique gave the following presentation.

Background

The population of Mozambique is 18 million with a prevalence of 12.2%, expected to rise to 14%. The VCT program started in 2001 with currently over 30 sites run mostly by NGOs. CDC supports the Ministry of Health in the coordination of activities. USAID has invested in some VCT activities. One hundred million dollars has been dedicated towards HIV/AIDS. There are currently 11 PMTCT sites, although none are USAID/CDC. FHI is developing a plan for USG to build onto existing PMTCT structures.

CDC's focus in the IOP is to provide technical assistance to the MOH

There is not much experiential data available in Mozambique and the program also aims to transform guidelines into a model, drawing together isolated activity throughout country.

Working through FHI the Initiative plans to establish complete PMTCT packages starting in five sites, with a special focus on community linkages. With only 40% ANC coverage in Mozambique, community linkages are especially important. The ministry has struggled to perform a coordinating function to date so the aim is to bring it all together.

While plans are still in their inception the objective is to create scaleable models as well as linking NGOs with communities. Christian mentioned that frameworks from South Africa, Rwanda and Uganda will also be drawn upon in the development of Mozambique's model guidelines.

Mozambique was one of the countries who cited difficulties with the language barrier and they have set up a relationship with Brazil and an exchange of youth groups has already taken place and a visit from the Brazilian minister.

Rwanda

Barbara Sow, USAID, Rwanda gave overview of Rwanda's PMTCT program.

The program consists of 33 PMTCT sites out of 325 healthcare centers. Services are focused but coverage is not general. The Global Fund has started and seeks to expand VCT, OIC, STIS and PMTCT services. The national program aims to have at least one VCT site in each of the 39 districts and the USG Initiative will support it. The key objective of the Initiative in Rwanda is to support the government roll out of the Global Fund, including strategic planning for MTCT, lab development, improving tools for services, community mobilisation – all to make VCT more effective.

Specifically the IOP aims to assist government with the roll out of 39 new sites. CDC will perform a central function providing lab support, monitoring and evaluation, curriculum development, support for logistics, procurement and drug supplies.

USAID will be involved in implementation at a district level. Activities will focus on materials, quality control, maternal care, couples counseling, malaria and TB, providing more comprehensive antenatal care - supporting between 17 and 28 sites, with complete coverage in five sites over the next five years.

Joint programming between USAID and CDC will also take place. CDC will be providing technical assistance at two of the sites where HAART is being implemented. PMTCT and HAART sites will work alongside to meet the quotas of pregnant women and families who are able to access HAART.

The relationship between USAID/CDC and the government is Mozambique is a complementary linkage. Communication is important feature in the relationship between CDC and USAID. We talk daily and join forces when we negotiating with government.

Discussion

Barbara confirmed that the Global Fund was for 15 million over three years and is divided into eight sub-components such as youth, PLWAs, and so on. There is a vertical monitoring and evaluation system each with each site submitting hard copies of their statistics and some donors collecting electronically. The aim is to develop a comprehensive and integrated process and integrated with VCT and TOIY. Management is critical to successful monitoring and evaluation and includes training around project monitoring and role clarification.

South Africa

Gray Handley, International Health Attaché, HSS, Pretoria said that he would distribute a copy of his PowerPoint Presentation to participants. His presentation addressed the status of the epidemic in South Africa.

See Appendix 6

Status of PMTCT

- 96% of antenatal women register at a healthcare facility
- 83% deliver in healthcare facilities
- There is a prevalence of 10,5 % with 75 000 new MTCT infections per year
- Two years ago there were 193 feeder clinics focusing on PMTCT.
- Currently there are 500 out of a potential 4000 sites.
- The initiative has been broadly successfully with an uptake from 20 – 97 %.

IOP and IP

CDC, USAID and the Ministry of Health have engaged in a tripartite consensus building technique in the development of the IP. During the IOP phase there will be no procurement but grants will be made for the purposes of:

- Providing assistance to selected provinces for the expansion of their PMTCT services
- Improving physical infrastructure
- Supporting home-based care programs and exploring the costs of these services
- Supporting the communication and stigma components of the PMTCT program
- Improving monitoring and evaluation
- Supporting research to assess side effects of Nevirapine
- Supporting the use of HIV treatments including ARVs
- Supporting staff and capacity building

Challenges

- Working with the Department of Health
- Ensuring flexibility of funding mechanisms

- Building capacity at a national, provincial and district levels
- Implementing plans
- Coordinating with other initiatives including the Global Fund
- Bilateral and multilateral donors
- Managing data
- Promoting lay counselors – many provinces recognise such counselors
- Working with political leadership in South Africa is the single most important issue facing research and development in South Africa. A strong national leadership is of crucial importance and in South Africa leadership has been lacking and often serves to undermine an understanding of HIV/AIDS.

Discussion

Gray was asked to comment on the site with 97 % uptake. He responded that there are actually two sites: The Soweto-based site - supported by USAID working with the Peri-Natal HIV Unit, Baragwanth Hospital and an NGO - offers comprehensive services including prenatal, antenatal and community components. The partners provide a high level of antenatal support as well as home-based care, child social support, youth services, palliative care and more. The other site is the Cape Town-based Mothers to Mothers site, which is the model that USAID is following.

Gray remarked that the program conducts CCVT – Compulsive Counseling and Voluntary Testing - rather than VCT and noted that this is a well-funded component of the program.

Nevirapine regulation emerged as a topic for further discussion. *Gray* explained that this was part of the political controversy, which includes questions about the efficacy of Nevirapine. The USG continues to provide efficacy data to the Medical Control Council. This is linked to the sensitivity among government officials towards ARVs and their use. Resistance to Nevirapine is a technical issue and this is still under review.

Namibia

Kirk Lazell, USAID, Namibia gave the following overview of PMTCT in Namibia.

- 1.8 million people are currently infected with a prevalence of 22%
- There are and estimated 250 000 infections

- 6000 babies are infected each year
- 75% of mothers deliver in healthcare facilities
- Activities are coordinated by an HIV/AIDS Directorate
- The government's second national AIDS plan has been developed as an extension of their previous plan and dovetails neatly with funding
- Funding from the Global Fund will be directed towards the development of strong coordinating mechanisms, going to NGOs rather than government.
- The government's PMTCT plus program started in March 2002 as a pilot program focusing on 400 women per site. The government has realized that it needs to expand PMTCT and has also allocated Global Funds for this.
- It is estimated that there will be 114 000 orphans by 2004, which has encouraged the Minister of Health to opt for PMTCT plus.
- VCT was only introduced in January 03 by PSI and the EU. There are still only five sites, although two government hospitals have VCT services. CDC and USAID will be targeting hospitals and clinics run by faith-based organisations with some government support for running costs. Plans include expansion into six government sites and five faith-based hospitals over the next year and government also plans to roll out of HAART.
- There is no problem with the use of Nevirapine and supplies of ARVs are sufficient for the first year – the Global Fund and the President's Initiative can then supplement this.

Challenges

- Building the capacity of human resources
- Increasing the numbers of skilled people
- Monitoring and evaluation
- Coordinating logistics
- Reducing stigma and discrimination

Leonard Floyd, CDC, Namibia added that CDC has only been working in Namibia for nine months. The Ministry of Health is their primary partner and the President's Initiative will help CDC expand their program with regard to PMTCT, VCT and the roll out of ARVs. The program cooperates with the Peace Corps and uses video conferencing as a training tool. The primary challenge is working with the Ministry and building an environment of trust. He noted that

there is still some suspicion as a result of the impact of apartheid in that country and hopes to continue working with the Ministry in a transparent manner.

Tanzania

Jim Allman and Patrick Swai, USAID, Tanzania represented Tanzania at the meeting. They highlighted that finding adequate USAID and CDC staff for their offices in Tanzania has been tricky. They presented a PowerPoint Presentation highlighting the plans for the President's Initiative, exploring how it can support the National Plan. The lack of capacity in Tanzania received significant attention.

See Appendix 7

Discussion

It was confirmed that the declining number of women giving birth in a facility is due to declining quality of healthcare facilities as well as the attitudes of service providers.

Ethiopia

Holly Dempsey, USAID, Ethiopia and Tadesse Wuhib, CDC, Ethiopia presented a comprehensive overview of the current activities and status of the epidemic in Ethiopia, along with a detailed explanation of their IOP.

See Appendix 8

Holly Dempsey revealed that, on the verge of famine, Ethiopia's situation is fairly unique. The focus of the entire US mission has shifted to avert excess mortality resulting from the drought. She added that a recent terrorist threat had resulted in the temporary closure of the USAID office. She highlighted that essentially the program is starting from the beginning in Ethiopia.

- Life expectancy stands at 41 years
- Prevalence in urban areas is 13.5 % and 3.7% in rural areas
- There have been a million deaths to date
- There are 200 000 children with AIDS and 1.2 million orphans
- 37 000 children are infect at birth each year

The USG proposal includes:

- PMTCT sites at a national, district and local level with a focus on training materials, management systems, monitoring and evaluation, infrastructure development and so on.
- Introducing PMTCT plus services

- Developing partnerships, which have proven crucial in the mobilisation of communities and other stakeholders.

- Incorporating lessons

- Developing three Centers of Excellence as well as a regional Centre of Excellence.

- Developing materials, procurement and monitoring & evaluation systems.

Holly noted that this is an opportunity for the program to coordinate and guide PMTCT activities. Initially the IOP looks at national level, with the Center of Excellence, as well as developing services and materials at a community level.

Discussion

During discussion it was suggested that USG explore why urban women tend not deliver at facilities – Eighty percent access antenatal services at least once but only 25% actually deliver at a healthcare facility. It was also asked whether this could be related to the infrastructure. It was noted that where a large percent of women are delivering it is possible to develop a strategy; however there is a general reluctance to seek antenatal care.

Holly noted the importance of a Safe Motherhood Program in Ethiopia, as one of the countries with the highest maternal mortality rates. She added that access is a real issue with the majority people four hours away from the nearest health post. She concluded that most deliveries in healthcare facilities are a result of obstructions, which is obviously not ideal.

Afternoon session: Field to field communication

Amanda Gibbons stated that the purpose of the next two sessions is to improve the flow of communication. She emphasized the communications remain a difficult challenge - how to communicate best practices, how to communicate best with each other and how to communicate with Washington/Atlanta. During this session various colleagues were called upon to share their perspectives.

Experiences

Barbara Sow, USAID, Rwanda and Valerie Koscelnik, CDC, Rwanda

Barbara emphasised how useful it has been that firstly her and Valerie were friends before they worked together in Rwanda. Secondly she stressed that it is so helpful that Valerie had worked with USAID before since they were able to collaborate based on a common understanding of the internal workings of USAID. Thus Barbara recommended that one element of good communication would be to educate each other about how your structure works from both the USAID and CDC side.

Another lesson, which they have found effective, is by organizing joint meetings with external agencies like the Clinton Foundation or the Global Fund. This has meant that the same information is received and the USG are able to present a consolidated view, minimizing any possibility of misunderstanding or broken telephone. They also

approached the Rwandan government requesting joint meetings. Joining forces has made them stronger, more effective and the government is more willing to listen.

Barbara has also drawn on this experience in her work with cooperating agencies (CAs) and the USAID/CDC nucleus has grown to include the CAs they're working with. Also government looks at us a one partner and looks at how they can use our assets together, which has proven extremely constructive from all sides. Ultimately it is an issue of teambuilding we need to find the marriage point.

Valerie added that it is also useful to be able to confirm information and compare notes with each other. It also means that both parties bring different skills to the table. USAID's focus is much broader extending to general development issues, agriculture, maternal health, family planning and so on. The collaboration means that USAID can keep CDC up to date on pertinent linkages in the field.

Mary Jordan, USAID, Washington is responsible for Public-Private Partnerships in Washington. She noted that partnerships with the private sector depend on collaboration inside and outside Washington. She reported that her work is only meaningful in how it relates to those on the ground. She told of how she had been involved in the public-private partnership with Heinekin in Rwanda and the collaboration between USAID and CDC contributed significantly to the success of this process.

Discussion

Some participants pointed out that it is difficult to institutionalize such a relationship but asked how they could learn from this lesson. Setting up regular joint meetings was one of the suggestions from *Valerie* and *Barbara*. They also highlighted how they had made it clear to the Ambassador that they were both working on HIV and had complementary skills to offer. This has meant that there is no one within the USG community who is pulling them apart.

The Embassy in Rwanda has now also established a regular CDC/USAID forum. Ultimately they concluded that it is about breaking down walls and getting to know and understand each other and how we work.

Peter Kilmarx revealed that there is no bilateral activity in Botswana. CDC participates as part of a technical review committee involved in the selection of USG partners in Botswana.

There was a question about how funds are processed outside capital cities expediently and it was noted that in non-presence countries, like Botswana and Cote d'Ivoire there is usually a point person in the Embassy who would be responsible for this.

Christian Barrat, revealed that there are currently efforts to establish a joint front with the USG in Mozambique. He indicated that this would be especially useful in terms of monitoring and evaluation. He also pointed out that the IOP does map out collaboration between USAID and CDC.

It was concluded that the experience is unique in Rwanda. Some participants felt that it might be worth ensuring that CDC and USAID are located in the same venue to harmonise collaboration.

Karen Shelley, USAID, Zambia, said that focusing on the Ambassador has really helped. At the end of 2000 a team was established incorporating all USG partners - Peace Corps, CDC, USAID, Embassy, Public Affairs – meeting bi-monthly at the mission and quarterly with the Ambassador. Both Ambassadors have been aware of HIV and USAID

and CDC work closely. When CDC entered the country TB was identified as a gap in the program and the team is currently investigating how to incorporate TB and PMTCT. The informational meeting with Embassy staff have assisted in keeping them abreast of developments in the program with all partners bringing different strength, all to support the national program.

David Stanton agreed saying that both partners bring different strengths to the table and he always tries to assess where CDC's strengths are, and never tries to be a development agency.

Margaret Achom-Okwero, CDC, Uganda said that the collaboration is working well in Uganda. Meetings are held together and they are currently preparing to work together on the PMTCT Initiative. There is a growing sense of trust, joint ownership and responsibility.

Amy Cunningham, USAID, Uganda proposed that information and the communication of basic principles is vital and suggested that it might be worth investing some resources in formal team building**.**

Amanda Gibbons, USAID, Washington asked *Amy* to talk about the collaborative relationship between USAID and CDC in Uganda, where both staff are relatively new to the country.

Amy responded that they have a joint mechanism, which was developed by USAID and CDC leaders, based on service delivery in sixteen districts. Quarterly review meetings led jointly by CDC and USAID have worked well and the mechanism has the potential to make a valuable contribution to HIV/AIDS in Uganda.

Mark Dybul said that USAID and CDC are also work well at the central level. Systems of collaboration are being built along similar lines, with joint leads, joint budget systems and cooperative agreements. He emphasised that good systems are useful to fall back on when pressures emerge. He concluded that investing in systems of collaboration pays off in the long run.

A comment on USAID/CDC collaboration around the establishment of centralized procurement was that all participants enjoyed getting together, it was exciting and more was accomplished in three weeks than three months

There was a call for practical recommendations.

Recommendations

- One issue that emerged was the establishment of mechanisms to assist embassies to move resources quicker. One input suggested that USAID and CDC can work as closely as possible but ultimately it is driven by who can access the money in a timely manner. There was a suggestion that Washington develop guidelines to streamline methods of ensuring that the money gets in country and to agencies quicker. This could take the form of a reporting kit outlining useful methods of spending resources promptly. In the past the amounts of money have been small but with these large funds it will prove to be a real challenge.

- Another practical question emerged around whether countries change their field support tables. It was confirmed that they could.

- Introducing consultation sessions at the beginning or end of home-leaves was another suggestion.

- *Valerie Koscelnik* supported contracting issues, saying that these represent new opportunities to break some of the existing rigid mechanisms.

- *Peter Kilmarx* felt that the technical tools are available and it is the administrative issues around access to funding, which are holding programs back. For instance, in CDC the only money available for spending is petty cash, even though there are a million dollars at its disposal. ***This issue was flagged for further consideration in Washington.***

- *Adriel Bush* suggested that field staff should create a flow chart outlining the steps they have to perform in order to sign a contract. This would enable them to take it up with their Washington colleagues. *Michele Maloney Kitts, Melinda Wilson, David Stanton* and *Michael Strong* volunteered to communicate how money is spent in the field.

- *Michele Moloney-Kitts* was concerned that CDC can only contract directly with governments, whereas USAID may not, due to issues such as corruption as well as the burden of management. She suggested creative thinking around new mechanisms to figure out new ways of moving money – possibly by using other partners, even local partners, since this could be used as an opportunity to build capacity in-country.

- It was confirmed that there are always mechanism available to assist in the movement of funds, the mechanisms just need to be identified. A legislative hurdle is that USAID can't transfer more than 25 million dollars to CDC. H/Q pointed out that this is one of the reasons for joint procurement mechanisms, which would relieve the burden of perpetually contracting.

- One development is the realization of the comparative advantage and the synergy that comes from working together. In some countries PMTCT activities started by passing money from CDC to USAID through FHI, the POLICY Project and other CAs. Meetings promote a growing and effective collaboration. The mandate to scale up national capacity means that not funding governments directly is not an option.

- Lack of contracting authority in the field is a major challenge for CDC and embassy partners. The purchasing of services through performance-based contracts have proven effective in Kenya.

- *Polly Dunford* reemphasized that Washington seems to lack a comprehensive understanding of the magnitude of the situation in the field. She proposed more communication between the front office and program office to facilitate the flow of information.

H/Q to field communication

Nithya Mani, Field Communication Coordinator, USAID, Office of HIV/AIDS; Sara Allinder, Regional Advisor for the Western Hemisphere, Department of State; Karen Stewart, White House Office of National AIDS Policy

Nithya explained that work in the Communications Workstream center on the facilitation of communication from H/Q to the field to ensure that those in the field are receiving the same message and are kept up to date with developments at H/Q. The Workstream plans to disseminate a monthly e-mail update to inform the field of developments across all the workstreams. *Nithya* raised the subject of a developing a website, asking whether this would be useful and if so,

what types of information would fieldworkers like to be able to access over the internet. Amanda Gibbons stressed that H/Q wants to strike a balance – what is enough and what is too much?

Holly Dempsey felt that while there is much information in Washington this is not the case in the field. She expressed that she would appreciate updates from H/Q and also the need to create a platform for the sharing of information, for instance, practical information about experience with lay counselors and so on.

The question was how regularly should this communication take place - H/Q appreciate that the field do not want to be bombarded. Suggestions included posting all information to the website or a listserv, which would provide a platform for information exchange. Another focus for discussion was the specific types of information that the field would find useful.

Michele Moloney-Kitts suggested regional meetings to enhance communication and information sharing. She told of how USAID's Regional HIV/AIDS Program Southern Africa meeting biannually with PHN officers. She felt that meetings such as these provide opportunities to focus on important technical questions, questions which don't receive sufficient attention due to the usual time constraints.

Christian Barrat, USAID, Mozambique expressed that he would prefer avoiding e-mail but felt that a website for information sharing would be great. He also suggested that countries could post their resources onto the site, which would also mean that resources could be shared.

Polly Dunford confided that she simply doesn't have the time to spend on the web – or to compile material for a website. She felt that formalizing information sharing is time-consuming but felt that informal meetings would be useful, saying that, "we might not feel like meeting but always find them useful when we're there." It was agreed that there is no substitute for face-to-face communication.

Recommendations

- Meeting annually or bi-annually to network, share information and discuss technical issues, such as infant feeding and so on. USAID and CDC would lead these HIV/AIDS specific meetings but other stakeholders could be invited. These events could potentially be organised around major HIV/AIDS events such as the ICASA Conference in September 2003 (It was confirmed that this meeting is still scheduled to take place).

- Publishing a donor newsletter

- Publishing some kind of a newsletter that is high quality and useful internally

- Developing a website. This suggestion generated a mixed response. Some felt that a site is too hard to maintain. Others felt that is would be extremely useful since it houses different levels of information, allowing people to gain an in-depth understanding, as well as linking to other pertinent sites on the internet. While some felt that it would also provide a forum to post key issues and questions others felt that such a forum would be under utilized.

- Compiling 'toolkits' of sample material at H/Q, which could include practical information such as a menu of services, a contract format, new guidelines and so on. This could take the form of a quarterly e-mail.

- Employing a documentation person to track progress and to record the experiences from the field.

- Developing a standardized job description for the person responsible for reporting back on this Initiative.

- Holding weekly conference telephone calls. This suggestion related particularly to those involved in workstreams. There was a sense that as the program grows so too will the need for regular communication. It was reported that this has proven very successful since it allows for direct feedback. Although it is difficult to coordinate diaries, it was recommended that participants organize their schedules plan around them.

- Developing a standardized slide show about the Initiative, which could be translated into French and other languages?

- Participating in a workstreams was also identified as a strategy to facilitate information-flow. Participants were encouraged to invest some time by participating in these decision-making structures. It was pointed out that workstreams are never full and potential volunteers were asked to sign up during the technical assistance session.

The Communications Workstream emphasised that it will also be looking at external communication and how to communicate with partners. *Nithya* said she would welcome any ideas, which could be sent to her via e-mail.

Technical Input

Nina Wadwha, International Health Fellow, USAID Washington

Nina requested feedback from participants around the draft MTCT technical guidance document that she is currently updating. She provided an outline of the document and directed participants to selected sections, which focused on fourteen areas. In particular she asked whether the areas are useful, the format helpful, the technical guidance relevant and what else they would like to see included.

She confirmed that the document is aimed at PHN officers.

Recommendations of new areas included:

- Commodity management

- Stigma and discrimination

- Infant feeding

- Peer review articles

- Different approaches Nevirapine (Nina was directed to a website called Women, Children and HIV)

- Post exposure prophylaxis for infants whose mothers have not received ARVs

- PMTC plus

- CDC policies

Nina agreed to incorporate these recommendations. Participants felt that this document is a great idea and suggested that it could take a binder format, which would allow it to be updated regularly. The document could be available on the Internet but also put together in such a way that it could be used to develop handouts. Some felt that this could be used to answer various questions posed by governments. *David Stanton* cautioned that it may be too broad and ran the risk of never being finished. He also expressed concern with the incorporation of peer review articles, which have not yet been accepted as common practices.

The Implementation Plan (IP)

Susan Settergren, Consultant, Office of the Director, CDC/GAP, Atlanta

Participants were encouraged to think of how their Implementation Plan for the MTCT Initiative will support the Emergency Plan since it is the foundation for the Emergency Plan.

Susan referred participants to the Draft IP Application Form. She highlighted how the Program Services, Monitoring and Evaluation and Procurement workstreams had collaboratively developed the IP. She stressed that this was still a very early draft and indicated that the Steering Committee have also received a copy of this draft.

The IPP was intended as a starting point to assist countries in thinking where they are headed and what they need to get there. She clarified that although this is an IP, a progress report will still be required.

Part One of the IP consists of an interim progress report, which is essentially an elaboration of the IOP table with information categorized according to program elements. Susan acknowledged that timeframes would cover different periods depending on when the IOP was submitted but confirmed that this would cover the period till November 2003.

Part Two of the IP is a detailed Annual Implementation Plan. Based on the table in the IPP, this represents a detailed account of your vision for the next five years as well as specific plans for the next fiscal year categorized according to program elements.

- Some additional questions have been added by the workstreams to assist in the provision of information about programs. For instance under Program Management it has been suggested that a timeline is developed for the program over the year.

- *Susan* referred participants to *Table 3* and clarified that this refers to a list of key partners, who are instrumental to the success of the program, but not funded by the Initiative. These would include multilateral or bilateral partners, Ministries of Health and so on.

- *Susan* said the challenge would be Section C, which is similar to the IOP but refers to FY04. She reminded participants that staffing (outside of CDC or USAID direct hires) should not be categorized under Human Resources but rather under the relevant program element.

She went on by referring participants to Section D, the Table of Indicators and Targets.

- On *Page 10* she indicated that they should ignore the grayed-out blocks because they were not applicable.

- On *Page 11* participants were instructed to remove last row of the table, which reads '*Percent of pregnant women testing HIV+ who receive a complete course of therapeutic or prophylactic combination ARV the prevent MTCT.'*

- On *Page 11* participants were instructed to remove the word prophylactic from the row above so that it would read, *'Percent of pregnant women testing HIV+ who receive a complete course of ARV to prevent MTCT (g/e).'*

- With regard to *Table 5c* on *Page 11* and *Table 5d* on *Page 12* there was a query about the definition of USG sites, which appeared to be different. It was suggested that perhaps the target should not be quantity-based, i.e. the number of USG supported sites, because support is difficult to quantify - Many sites are supported by a number of players and this also suggests that quantity is what we are trying to achieve.

- H/Q acknowledged this input saying that because of their on-the-ground experience guidance from fieldworkers is of crucial importance in the development of these indicators. H/Q also recognised that most USG initiatives aim to support national programs so it would be difficult to distinguish between USG and national indicators.

- It was noted that support at sites could be categorized into high and low – meaning a high level of USG support or a low level of USG support.

Susan concluded the indicators section by acknowledging that the IP assesses the *easy-to-measure clinical indicators*, but not those that are harder to measure like reducing stigma or national systems that will be sustainable over time. She said that these are, however, core indicators that will be measured across every country. Obviously balance is necessary and she pointed out that this is where *narrative reports* and the *five-year vision* are valuable.

The final section of the IP looks at a country profile. *Omotayo Bolu, Medical Epidemiologist, CDC, Atlanta* revealed that these had been developed at H/Q and came out of a baseline assessment conducted in each country. She said that these two-page summary reports provide a profile of each country before the launch of the Initiative. H/Q revealed that they had examined the latest demographic data and some country profiles had been updated since their submission. *Amanda* noted that country profiles were available at the meeting and needed to be approved urgently because they represent the starting point for the Initiative in each country.

Comments

- It will be difficult to state five-year objectives before knowing how much funding will be provided.

- *Page 6:* There seems to be shift in Program Management from the previous emphasis on supporting national capacity to an emphasis on USG Program Management

- *Table 4a Page 9:* Should countries insert a row under Human Resources if their inputs cannot be located into the existing categories?

- *Page 11:* Number of health workers newly trained is not a figure that is currently being tracked in a number of countries

- How do you define someone who is trained? H/Q acknowledged that it is difficult to quantify training but this figure is necessary just as an indication to demonstrate progress to Congress.

- How do you measure if someone is taking the treatment? You can only really measure who takes it home.

- How detailed and specific do these figures have to be - What if we don't know the national targets? This was flagged for further discussion with H/Q and it was recommended that this is included in the cable.

- One solution could be to use only the USG target since it is assumed that USG targets and national targets are the same.

- It was suggested that indicators *b. # of women attending at least 1 ANC visit at a PMTCT site who accepting HIV testing* and *f. # HIV+ pregnant women who receive HIV test result and post-test counseling in Table 5e* call for qualitative judgments and should be eliminated. It was also stated *that h. Estimated number of HIV-infected pregnant women* was unclear whether this is a national estimate or an estimate at the sites where the USG is involved.

- At a general level there was an appeal for the inclusion of indicators focusing on to primary prevention, family planning, and replacement feeding. These could be based on the WHO indicators on prevention and family planning.

- It was asked whether PMTCT Plus is only relevant when it is given to pregnant women, or whether a PMTCT indicator during post-partum care could also be incorporated.

- *Michele Maloney-Kitts* pointed out that the incorporation of voluntary indicators would add to the richness of the indicators.

- With regard to twinning programs it was noted that they are hard to define and quantify. It was felt therefore that when measuring institutional relationships there has to be a reliance on factors like the description of activities and the number of participants.

- It was noted that the major difficulty, particularly with voluntary indicators, is that each country will define things in their own way. It was suggested that the issue should not be forced and perhaps these potential discrepancies could be dealt with through the use of footnotes.

- It was confirmed that these indicators would be streamlined with those of the Global Fund to make reporting less burdensome. The session was concluded and it was agreed that these comments would be synthesized for another draft for comment and followed by a final draft sent out for approval.

Closure

Introduction

Adriel Bush noted that participants do not have to obligate the entire sum in their IOP. She recommended that participants should not be too aggressive and rather than raising questions at H/Q they should exercise caution by balancing their obligation against what they can achieve. She reminded participants that there would be a review in November. She confirmed that procurement could begin as soon as the IOP has been approved, but cautioned that it should be spent wisely. She reassured participants that there is no rush to spend the money since it has been earmarked specifically for each country. On the other, she pointed out that de-obligation will raise questions in Washington.

Participants were reminded that comments on the IPPs were available electronically on CD as well as in hard copies in binders. She asked participants to hand in copies of the IOP even if they're still in draft format so that she could get a sense of where each country is in the IOP process.

Technical Assistance Needs

RJ Simonds facilitated this session to determine the technical assistance needs in the field. Participants expressed the need for assistance in areas such as:

- Strategic planning including: -
  - General planning assistance
  - Joint USAID/CDC planning around the IP and development of a country strategy
  - Strategic planning and the development of a vision, as PMTCT merges into the Emergency Plan
  - With regard to a country specific USAID strategy it would useful to get technical assistance around how the new strategies will change to reflect legislation.
- Mechanisms for moving money were also highlighted, particularly if a new mechanism is introduced
- Budgeting, procurement and monitoring and evaluation

Country Strategies

Michele Maloney-Kitts raised the issue of country strategies designs (detailed strategic plans for offices where funding exceeds one million dollars) required by USAID and how these would relate to the IPs. She asked whether H/Q would extend the deadline for these strategies so that they can be brought into line with the IPs.

It was emphasised that although this is not required by CDC, that they should nevertheless be involved in the development of these strategies.

Some countries reported that they had already submitted their strategies and were concerned that these would have to be redone. It was confirmed that there is no initial country that has had their strategy approved so there is still time to change them. It was agreed that this issue would be put on hold until H/Q has a sense of how the Emergency Plan will impact on the country strategies, rather than wasting time redoing it now. ***This issue was flagged for further discussion at H/Q.***

There was a question of clarity around the OMB target setting exercise in which USAID participated and CDC did not.

Follow Up Meeting

This issue of a follow-up meeting was discussed. It was explored whether this should be technical or administrative. There was a sense that there was a need to follow up on some of the planning for the President's Initiative and the Emergency Plan. There was consensus that meeting like this are a good mechanism to resolve communication issues.

The date for the meeting also came under discussion. It was noted that ICASA is taking place in Kenya in September and that a joint CDC/USG/USAID satellite meeting looking at contextual issues like OVC was suggested. *Michele Russell, USAID Regional, South Africa,* revealed that there is a regional USAID HIV/AIDS meeting scheduled for October/November. Participants felt that this would be good timing because by then the Emergency Plan should almost be finalized.

Michele Russell offered to facilitate a joint meeting with the regional program, which was hoping to focus on issues such as best practices.

Participants were thanked for their hard work and reminded to submit their IOPs to Program Services via e-mails, which should be sent to *Rene* and *Nathan* and copied to *Nithya* and *Omotayo*. Monitoring and Evaluation tools for data collection and facilities were disseminated.

Parking lot issues

Below is a list of parking lot issues that were raised but were not necessarily resolved

- Exploring increased salaries for providers of ANC/PMTCT services at health facility and community levels
- Providing more clarity around twinning - What is it? Who is it for? What is it for?
- Clarifying bilateral aspects - Is it Us to Africa or Us to Africa / Africa to Us?
- Clarifying details of the Emergency Plan and the delay
- Providing a target figure for OMB - What is their role / how do they fit in?
- Evaluating non-presence initiative countries – to be done by USAID
- Developing one set of best practices - not two
- Resolving the volunteer/twinning indicators
- Standardizing workstream meetings
- Indicators – streamline/consider carefully
- Introducing real time updates from Washington/Atlanta
- Finalizing the reporting cable
- Composing a communiqué to mission directors at the field's request
- Disseminating RPM plus document for ARV procurement
- Exploring the role of regional offices and how they could provide support where there is no mission.
- Disseminating changes in regulations as soon as possible
- Communicating summaries of workstream decisions to *Nithya*

Acronyms

IPP	Initial Program Plan
IOP	Initial Obligation Plan
MOH	Ministry of Health
IP	Implementation Plan
HG	Headquarters
MTCT	Mother To Child HIV Transmission
PMTCT	Prevention of Mother To Child Transmission
USAID	United States Agency for International Development
CDC	Centers for Disease Control and Prevention
USG	United States Government
ONAP	(White House) Office of National AIDS Policy
OMB	(White House) Office of Management and Budget
EPAR/PEPFAR	(President's) Emergency Plan for AIDS Relief